SOUTH CAROLINA BUDGET AND CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM

AUTHORIZED REPRESENTATIVE FORM

Note: This form is used to confirm permission for the health plan to discuss or disclose a subscriber's protected health information to a particular person who acts as the subscriber's Authorized Representative. Use of this information is strictly limited to that purpose described herein.

REQUESTOR'S INFORMATION

By signing this form, I understand and agree that the South Carolina Budget and Control Board Employee Insurance Program (EIP) may release my personal health information, defined as, but not limited to, identification of treating providers of care, personal diagnoses, procedures and demographic information (but not including any psychotherapy notes). I understand that this authorization does not provide my Authorized Representative with any authority, either implied or direct, over any treatment or direct-care decisions. I also understand that executing this form will not alter the manner in which EIP processes my benefits payments, enrollment/change forms or my eligibility for benefits.

Requestor's Name: _____ SSN:__ __ __ / __ __ / __ __ __ __

Address: _____

Telephone Number: _____ E-mail Address: _____

Policyholder's Name (if different from above): _____

Policyholder's SSN (if different from above): _____

AUTHORIZED USE AND/OR DISCLOSURE

Intended Use or Disclosure:
I understand that EIP's general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize EIP to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative #1:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Authorized Representative #2:

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

I understand that I have the right to limit the information that EIP releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure: _____

_____

_____

EXPIRATION AND REVOCATION

This authorization to release information to my Authorized Representative will automatically expire two years following the termination of my health plan enrollment.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named to remain my Authorized Representative, I must revoke this authorization, **in writing**, by giving written notice of my decision to the health plan contact listed below. I understand that my revocation of this authorization will not affect any action that EIP has taken, or any information that EIP has already released, based upon this authorization before EIP actually receives my request to revoke it.

Contact: Employee Insurance Program, Customer Service, Post Office Box 11661, Columbia, SC 29211
Tel.: 803-734-0678 (toll-free at 1-888-260-9430)
FAX: 803-737-0825

SIGNATURE/AUTHORIZATION

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request of the health plan and its administrator. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named as Authorized Representative(s) for the purpose described above.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.
Contact the Employee Insurance Program at 803-734-0678 (toll-free at 1-888-260-9430) if you have any questions.

PLEASE FAX OR MAIL THE COMPLETED AND SIGNED AUTHORIZATION FORM TO:

Employee Insurance Program
1201 Main Street, Suite 300
Post Office Box 11661
Columbia, SC 29211

FAX: 803-737-0825